Case Management Services

General Information

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m. - 5:00 p.m. (M-F)

* Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface

The Wisconsin Medicaid and BadgerCare Case Management Handbook is issued to case management providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Case Management Handbook consists of the following sections:

- General Information.
- Covered and Noncovered Services.
- Billing.

In addition to the Case Management Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

Provider Information

Provider Eligibility and Certification

General Requirements

Under HFS 105.51, Wis. Admin. Code, Wisconsin Medicaid certifies qualified entities electing to participate as case management providers. To become certified, providers must have:

- Qualified staff, as identified in this section.
- The ability to deliver all case management elements, as identified in the Covered and Noncovered Services section of this handbook.

Under HFS 105.51, Wis. Admin. Code, Wisconsin Medicaid certifies qualified entities electing to participate as case management providers.

Throughout this handbook, three different names are used to signify who may provide case management services. These names are *not* interchangeable. The following list defines the three types of entities:

- *Case Management Provider* — denotes the entity that meets the requirements as a certified case management provider and is assigned the Medicaid billing provider number.
- *Case Management Agency* — organizations with whom the provider contracts.
- *Case Manager* — individual who is providing case management services to recipients.

Private, Nonprofit Entities That May Be Certified

The following private, nonprofit entities are eligible for certification:

1. Independent Living Centers, as defined under s. 46.96(1)(ah), Wis. Stats.
2. Private, nonprofit agencies funded by the Department of Health and Family Services (DHFS) under s. 252.12(2)(a)8, Wis. Stats., for purposes of providing life care services to persons diagnosed as having Human Immunodeficiency Virus.

Public Entities That May Be Certified

Any of the following public entities (as defined by the relevant state statutes) are eligible to be certified case management providers:

1. County or tribal departments of community programs (51.42 and 51.42/.437 boards).
2. County or tribal departments of social services.
3. County or tribal departments of human services.
4. County or tribal aging units.
5. County or tribal departments of developmental disabilities services (51.437 boards).
6. County/tribal, city, village, town, or combined city/county/tribal public health agency, and multiple county/tribal health departments (as defined under s. 251.02, Wis. Stats.).

Per HFS 105.51(7), Wis. Admin. Code, public entities are eligible for case management certification if the local government has elected to participate in this service. Also, the local government must have state statutory authority to operate community programs necessary for the population(s) to assure effective monitoring and coordination of these critical services.

To provide case management services, the case management provider's county, village, or town board of supervisors, city council, or Indian tribal government must elect to provide the services [s. 49.45(25), Wis. Stats.]. Therefore, at any time, a county, city, village, town, or tribal government may send notice of termination of, or amendment to, participation as a case management provider to Wisconsin Medicaid. Such notice supersedes any prior action by the case management provider within the county, city, village, town, or tribal jurisdiction.

Eligible private, nonprofit entities do not need approval from a county, village, or town board of supervisors, city council, or tribal agency.

General Qualifications of Staff Providing Case Management Services

Qualifications for Performing Assessments and Case Plans

As defined in HFS 105.51(2), Wis. Admin. Code, case managers performing assessments and case planning must meet both of the following requirements:

- Knowledge of the local service delivery system, the target group's needs, the need for integrated services, and the resources available or needing to be developed.

- A degree in a human services-related field and one year of supervised experience, or two years of supervised experience working with people in the target population, or an equivalent combination of training and experience.

The certified case management provider is responsible for ensuring that its own or subcontracted staff meet these requirements.

Determining a Human Services-Related Field

Wisconsin Medicaid rules do not define a human services-related field. Since degree requirements vary, case management providers must review the prospective case manager's records to identify the amount of course work completed in areas relevant to case management. Some examples of relevant course work might be human development, long term care, and psychology.

Case management providers must look at training, experience, or a combination of training and experience to make a determination of equivalency to the standards. For the purposes of meeting these requirements, a registered nurse with a bachelor's degree in nursing is considered to have a degree in a human services-related field.

Qualifications for Providing Ongoing Monitoring and Service Coordination

Case managers providing ongoing monitoring and service coordination must have knowledge of the following:

- Local service delivery system.
- Target population's needs.
- Need for integrated services.
- Resources available or needing development.

Case managers typically gain such knowledge through one year of supervised experience working with people in the designated target populations.

For example, a certified alcohol and other drug abuse (AODA) counselor qualifies to provide case management services for a person with alcohol or drug dependence. However, for an elderly recipient, that AODA counselor may *not* qualify to perform case management services. The case management provider must

The certified case management provider is responsible for ensuring that its own or subcontracted staff meet these requirements.

have available on request its policies and procedures for determining an individual case manager's qualifications, as well as documentation of its case manager's qualifications. A case management provider must make and document any determination of qualifications based on equivalency using written guidelines and procedures. The certified case management provider is responsible for the determination of equivalence for its own or subcontracted staff.

Subcontracting for Case Management Services

It is the certified provider's responsibility to ensure that the subcontractor provides services and maintains records in accordance with the Medicaid requirements for the provision of case management services.

Medicaid-certified case management providers may contract with noncertified case management agencies for any case management service. However, the Medicaid-certified provider retains all legal and fiscal responsibility for the services provided by subcontractors.

It is the certified provider's responsibility to ensure that the contractor provides services and maintains records in accordance with the Medicaid requirements for the provision of case management services. According to HFS 105.02(6)(a), Wis. Admin. Code, the following records must be maintained:

> Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by MA.

For more information on recordkeeping as it relates to case management services, refer to the Covered and Noncovered Services section of this handbook. Please refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional information on required recordkeeping.

The Medicaid-certified provider is responsible for ensuring that its contractors:

- Meet all program requirements.
- Receive copies of Medicaid handbooks and other appropriate materials.

Wisconsin Medicaid sends provider materials to Medicaid-certified providers only, unless materials are specifically requested by individuals or agencies who are not certified by Wisconsin Medicaid. Published issues of *Wisconsin Medicaid and BadgerCare Updates*, the All-Provider Handbook, this handbook, and other provider publications may be reviewed and downloaded online at *www.dhfs.state.wi.us/medicaid/*.

Although the contracted case management agency may submit claims to Wisconsin Medicaid using the certified provider's Medicaid number if the provider has authorized this, Wisconsin Medicaid only reimburses the certified provider.

Scope of Service

The policies in this handbook govern all services provided within the standards defined in s. 49.45(25), Wis. Stats., and HFS 105.51 and 107.32, Wis. Admin. Code. Refer to the Covered and Noncovered Services section of this handbook for covered services and related limitations.

Terms of Reimbursement

Medicaid reimbursement is based on a uniform, contracted hourly rate set by Wisconsin Medicaid. This hourly rate applies to all services provided by the certified case management provider or by agencies or individuals contracted by that provider for case management services. The provider receives the federal share of the hourly contracted rate from Wisconsin Medicaid for all hours of allowable service.

Refer to Appendix 1 of this section for clarification on the federal share and general program revenue "matching" and related services. Refer to the Billing section of this handbook for billing instructions.

Provider Responsibilities

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for specific responsibilities as a certified provider, including:

- Additional state and federal requirements.
- Fair treatment of the recipient.
- Grounds for provider sanctions.
- Maintenance of records.
- Recipient requests for noncovered services.
- Services rendered to a recipient during periods of retroactive eligibility.

Provider Sanctions

According to HFS 106.09(2), Wis. Admin. Code, the certified case management provider is liable for the entire amount of an audit adjustment or disallowance attributed to the provider by the federal government or DHFS.

Refer to Appendix 3 of this section for a Wisconsin Medicaid Case Manangement Self-Audit Checklist. This checklist was developed as a guide to assist Wisconsin Medicaid case management providers in assessing their level of compliance with Wisconsin Medicaid case management policies and procedures. The use of this checklist is strictly voluntary. Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional requirements.

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for specific responsibilities as a certified provider.

Recipient Information

Recipient Eligibility

Wisconsin Medicaid providers should ***always*** verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility. Refer to the Provider Resources section of the All-Provider Handbook for more information about these methods of verifying recipient eligibility.

For recipients, participation in the case management program is voluntary. The recipient voluntarily participates in case management services by maintaining contact with and receiving services from the case management agency.

Eligibility Categories

Wisconsin Medicaid classifies recipients into one of several eligibility categories, including special benefit categories. These categories allow for a differentiation in benefit coverage. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information about special benefit categories.

Case management is *not* a separately payable service when provided to nursing home recipients, except within 30 days before nursing home discharge.

Case management is *not* a benefit for Qualified Medicare Beneficiary-only (QMB-only) recipients. Qualified Medicare Beneficiary-only recipients are eligible for Medicaid payment of the coinsurance and deductibles for Medicare-covered services only. Medicare does not cover case management services; therefore, Wisconsin Medicaid denies claims submitted for QMB-only recipients.

Copayment

Case management services are not subject to recipient copayments.

Freedom of Choice

For recipients, participation in the case management program is voluntary. The recipient voluntarily participates in case management services by maintaining contact with and receiving services from the case management agency. The case management provider may not "lock-in" recipients or deny the recipient's freedom to choose providers. Recipients may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers. For ongoing monitoring and service coordination, there is one, individual case manager known by and available to the recipient or guardian.

For a recipient receiving case management services, the following people may choose and, if necessary, request a change in the case manager who is performing ongoing monitoring and service coordination (subject to the case management provider's or agency's capacity to provide services under HFS 107.32(2), Wis. Admin. Code:

- The recipient.
- The recipient's parents, if the recipient is a minor child.
- A guardian, if the recipient has been judged incompetent by the courts.

The case manager and recipient/parent/guardian must discuss case plan changes and mutually agree to reduce or terminate services. If the case management provider or agency needs to reduce or terminate services for any reason, the case manager must notify the recipient in advance and document this in the record.

Case Management for Recipients Enrolled in Medicaid-Contracted Managed Care Programs

Medicaid-Contracted HMOs

Wisconsin Medicaid covers case management services on a fee-for-service basis for recipients enrolled in a Medicaid-contracted HMO, including Independent Care (commonly referred to as *i*Care) in Milwaukee. Since Medicaid-contracted HMOs and case management providers are responsible for coordinating care to recipients, Wisconsin Medicaid has developed guidelines to address the roles and responsibilities of each entity.

Refer to Appendix 2 of this section for coordination of services guidelines between HMOs and case management providers.

Special Managed Care Programs

The following special managed care programs include case management as a covered service; therefore, case management may not be billed separately to Wisconsin Medicaid for persons enrolled in these programs:

- Children Come First (CCF).
- Community Care for the Elderly.
- Community Health Partnership.
- Community Living Alliance.
- Elder Care Options.
- Wraparound Milwaukee (WAM).

Refer to the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for further updates to this list of special managed care programs.

For more information on case management for recipients enrolled in these special managed care programs, please contact the special managed care program directly.

Refer to the Provider Resources section of the All-Provider Handbook for information on identifying a recipient's managed care status.

Family Care

Wisconsin Medicaid does not separately cover case management services for recipients enrolled in Family Care. For more information on case management services for recipients enrolled in Family Care, contact the care management organization (CMO). A list of CMOs is included in the Family Care Guide, which can be found on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Community Support Programs

Wisconsin Medicaid does not reimburse case management providers for case management services provided to recipients receiving Medicaid-reimbursed community support program (CSP) services. Case management services provided to CSP recipients should be billed under the Medicaid CSP benefit, not the case management benefit. Information on CSP services can be found in the Wisconsin Medicaid Community Support Program Handbook.

Wisconsin Medicaid covers case management services on a fee-for-service basis for recipients enrolled in a Medicaid-contracted HMO, including Independent Care (commonly referred to as *i*Care) in Milwaukee.

Appendix

Appendix 1
General Program Revenue "Matching" Fund Requirements

Wisconsin Medicaid is funded by a combination of state/local and federal funds. In order for the state to collect the approximately 60% federal share, Wisconsin Medicaid has to secure approximately 40% as the state share. For Medicaid case management, existing state and local funding constitutes this state match. This could be county tax levy, Community Options Program funds, Family Support monies, Alzheimer's Caregiver Support funds, Life Care Services Program funds under s. 252.12, Wis. Stats., funding for Independent Living Centers under s. 46.96, Wis. Stats., or any state general program revenue (GPR) aids allocated to county agencies administering case management services to eligible recipients.

Medicaid-certified case management agencies must have sufficient state or local funding to serve as the nonfederal share of case management reimbursement and must maintain an audit trail to document expenditures for eligible recipients.

There are two limitations on funds allowable for matching funds:

1. Federal monies cannot be used to match the federal share of Medicaid dollars, unless the federal funds are authorized for this purpose.

2. Local funds already being used to match other federal funds cannot be used as a match for case management. Examples of this include:

    - The same local funds cannot be claimed as a match for community support program services and case management.
    - The same local funds may not be claimed as a match for maternal/child health block grants and case management.

Appendix 2

Guidelines for the Coordination of Services Between Medicaid-Contracted HMOs and Medicaid Case Management Agencies

The purpose of this attachment is to identify the roles and responsibilities of Medicaid-contracted HMOs and case management agencies when they are working with common recipients. This same language is also incorporated as an addendum to the HMO contract to ensure that both HMOs and case management providers have the same language available to them.

HMO Rights and Responsibilities

1. The HMO must designate at least one individual to serve as a contact person for case management providers. If the HMO chooses to designate more than one contact person, the HMO must identify the target populations for which each contact person is responsible.

2. The HMO may make referrals to case management agencies when they identify a recipient from an eligible target population who they believe could benefit from case management services.

3. If the recipient or case manager requests the HMO to conduct an assessment, the HMO determines whether there are signs and symptoms indicating the need for an assessment. If the HMO finds that an assessment is needed, the HMO determines the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO documents the rationale for this decision.

4. The HMO must determine the need for medical treatment of those services covered under the HMO contract based on the results of the assessment and the medical necessity of the treatment recommended.

5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required:
   - The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting.
   - The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the recipient or case manager.
   - The HMO case management liaison and the case manager must discuss who is responsible for ensuring that the recipient receives the services authorized by and provided through the HMO.
   - The HMO's role in the case planning may be limited to a confirmation of the services the HMO authorizes if the recipient and case manager find these acceptable.

Case Management Agency Rights and Responsibilities

1. The case management provider is responsible for initiating contact with the HMO to coordinate services to recipient(s) they have in common and providing the HMO with the name and telephone number of the case manager(s).

2. If the HMO refers a recipient to the case management provider, the case management provider must conduct an initial screening based on their usual procedures and policies. The case management provider must determine whether or not they will provide case management services and notify the HMO of this decision.

3. The case manager must complete a comprehensive assessment of the recipient's needs according to the requirements in the Case Management Services Handbook. This includes a review of the recipient's physical and dental health needs.

4. If the case manager requires copies of the recipient's medical records, the case manager must obtain the records directly from the service provider, not the HMO.

5. The case manager must identify whether the recipient has additional service or treatment needs. As a part of this process, the case manager and the recipient may seek additional assessment of conditions that the HMO may be expected to treat under the terms of its contract, if the HMO determines there are specific signs and symptoms indicating the need for an assessment.

6. The case management provider may not determine the need for specific medical care covered under the HMO contract, nor may the case manager make referrals directly to specific providers of medical care covered through the HMO.

7. The case manager must complete a comprehensive case plan according to the Case Management Services Handbook's requirements. The plan must include the medical services the recipient requires as determined by the HMO.

8. If the case manager specifically requests the HMO liaison to attend a planning meeting in person, the case management provider must reimburse the HMO for the costs associated with attending the planning meeting. These are allowable costs for case management reimbursement through Wisconsin Medicaid.

Nothing in these guidelines precludes the HMO and the case management agency from entering into a formal contract or Memorandum of Understanding to address issues not outlined here.

Appendix 3

Wisconsin Medicaid Case Management Agency
Self-Audit Checklist

This form is a self-audit checklist for case management policies only. Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional provider requirements. Use of this form is strictly voluntary.

Recipient:_____ Date:_____

Agency:_____ Checklist completed by:

_____

1. AGENCY REQUIREMENTS	YES	NO
The agency has accurately designated the target population(s) it will be serving.		
Written procedures are in place for determining and documenting a case manager's qualifications.		
Agency is in compliance with the Provider Rights and Responsibilities section of the All-Provider Handbook.		
A signature page is in the recipient's file, if initials are used in the documentation.		
2. RECIPIENT INFORMATION		
The client is Medicaid eligible and meets the definition of one or more of the target populations the agency has elected to serve.		
The person is not receiving Medicaid-covered hospital or nursing home services at the time the case management services are being provided, except when institutional discharge planning services are provided.		
For severely emotionally disturbed (SED) persons under age 21, there is documentation of the three-member team's (including a psychiatrist or psychologist) SED finding or the evidence that the child has been admitted to an integrated services project under s. 46.56, Wis. Stats.		
3. ASSESSMENT		
The following information, as appropriate, is completed and in the recipient's case file:		
a. Recipient identifying information (for example, the "Face Sheet").		
b. Record of physical and mental health assessments and consideration of potential for rehabilitation.		
c. A review of the recipient's performance in carrying out activities of daily living, such as mobility levels, personal care, household chores, personal business, and the amount of assistance required.		
d. Social interactive skills and activities.		
e. Record of psychiatric symptomatology and mental and emotional status.		
f. Identification of social relationships and support (informal caregivers, i.e., family, friends, volunteers; formal service providers; significant issues in relationships; social environments).		
g. A description of the recipient's physical environment, especially regarding in-home mobility and accessibility.		
h. In-depth financial resource analysis, including identification of, and coordination with, insurance, veteran's benefits, and other sources of financial assistance.		
i. Vocational and educational status and daily structure, if appropriate (prognosis for employment; educational/vocational needs; appropriateness and availability of educational, rehabilitational, and vocational programs).		
j. Legal status, if appropriate (guardian relationships, involvement with the legal system).		

Appendix 3
(Continued)

3. ASSESSMENT (CONT.)	YES	NO
k. For any recipient under age 21 identified as SED, a record of the multi-disciplinary team evaluation required under s. 49.45(25), Wis. Stats.		
l. The recipient's need for housing, residential support, adaptive equipment, and assistance with decision making.		
m. Assessment of drug and/or alcohol use and misuse for recipients indicating possible alcohol and drug dependency.		
n. Accessibility to community resources that the recipient needs or wants.		
o. For families with children at risk, an assessment of other family members, as appropriate.		
p. For families with children at risk, an assessment of family functioning.		
q. For families with children at risk, identification of other case managers working with the family and their responsibilities.		
4. CASE PLAN DEVELOPMENT		
The recipient's file contains a written case plan identifying the short- and long-term goals and includes the following information (for families with children at risk, the plan should address the Medicaid-eligible child and services to other Medicaid-eligible family members):		
a. Problems identified during the assessment.		
b. Goals to be achieved.		
c. Identification of formal services to be arranged for the recipient, including names of the service providers and costs.		
d. Development of a support system, including a description of the recipient's informal support system.		
e. Identification of individuals who participated in developing the plan of care.		
f. Schedule of initiation and frequency of various services arranged.		
g. Documentation of unmet needs and gaps in service.		
h. For families with children at risk, identification of how services will be coordinated by multiple case managers working with the family (if applicable).		
i. Frequency of monitoring by the case manager.		
j. The case plan is signed and dated. Each update to the case plan must be signed and dated.		
5. ONGOING MONITORING AND SERVICE COORDINATION		
a. For ongoing monitoring and service coordination, there is one, identified individual who serves as the case manager and is known and available to the recipient.		
b. All recipient collateral contacts, including travel time incurred to provide case management services, are recorded in the case file.		
c. All record keeping necessary for case planning, coordination, and service monitoring is recorded in the recipient's file.		
d. There has been at least one documented recipient or collateral contact, case-specific staffing, or formal case consultation during a month when time was billed for record keeping.		
e. The case manager has monitored the recipient and collaterals according to the frequency identified in the case plan.		
f. The case manager has signed (or initialed) and dated all entries in the recipient's file.		

Appendix 3
(Continued)

6. DISCHARGE PLANNING	YES	NO
a. Discharge-related case management services billed on a recipient's behalf who has entered a hospital inpatient unit, nursing facility, or ICF/MR (following an initial assessment or case plan) have been billed under procedure code W7062.		
b. Discharge planning services were provided within 30 days of discharge.		
c. Services billed as discharge planning do not duplicate discharge planning services that the institution normally is expected to provide as part of inpatient services.		
7. MAINTENANCE OF CASE RECORDS		
A written record of all monitoring and quality assurance activities is included in the recipient's file and has the following:		
a. Name of recipient.		
b. The full name and title of the person who made the contact. If initials are used in the case records, the file includes a signature page showing the full name.		
c. The content of the contact.		
d. Why the contact was made.		
e. How much time was spent.		
f. The date the contact was made.		
g. Where the contact was made.		
8. BILLING REQUIREMENTS		
One of the following activities has been performed prior to billing for targeted case management:		
a. Face-to-face and telephone contacts with the recipient:		
• To assess or reassess needs.		
• To plan or monitor services to ensure access or adequacy of services.		
• To monitor recipient satisfaction with care.		
b. Face-to-face and telephone contact with collaterals (paid providers, family members, guardians, housemates, school representatives, friends, volunteers, or others involved with the client):		
• To mobilize services and support.		
• To educate collateral of the needs, goals, and services identified in the plan.		
• To advocate on behalf of the recipient.		
• To evaluate/coordinate services in the plan.		
• To monitor collateral satisfaction or participation in recipient care.		
9. NONBILLABLE SERVICES		
Wisconsin Medicaid does not cover the following as Medicaid case management services:		
a. Diagnosis, evaluation, or treatment of a physical, dental, or mental illness.		
b. Monitoring of clinical symptoms.		
c. Administration of medication.		
d. Recipient education and training.		
e. Legal advocacy by an attorney or paralegal.		
f. Provision of supportive home care, home health care, or personal care.		
g. Information and referral services which are not based on a recipient's plan of care.		

Appendix 3
(Continued)

9. NONBILLABLE SERVICES (CONT.)	YES	NO
h. Ongoing monitoring to a resident of a Medicaid-funded hospital, SNF, ICF, or ICF-MR, except for the 30 days before discharge.		
i. Case management to Medicaid waiver recipients, except for the first month of waiver eligibility.		
j. Duplicative discharge planning from an institution.		
k. Services other than case management covered under Wisconsin Medicaid.		
l. For Group A target populations, more than one assessment or case plan per year with no change in county of residence.		
m. For Group A target populations, more than two assessments or case plans per year with a change in county of residence.		
n. For Group B target populations, more than two assessments or case plans per year.		
o. Costs for more than one case manager (unless there is a qualified temporary replacement).		
p. Services during periods in which the recipient was not Medicaid eligible, including periods of time when a recipient is detained by the legal process, is in jail or other secure detention, or when an individual 22 to 64 years of age is in an IMD.		
q. Interpreter services.		
r. Case management to recipients enrolled in Family Care, special managed care programs, or a community support program (CSP).		
s. Any service not specifically listed as covered in the Case Management Services Handbook.		

NOTE: In sections 1 through 8 of this checklist, the answers should be "yes." Answers to section 9 should be "no."

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

Collateral

A collateral is anyone who has direct supportive contacts with the recipient. Collaterals include family members, friends, service providers, guardians, housemates, or school officials.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS) and Wisconsin Medicaid.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Emergency services

Those services which are necessary to prevent the death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

Glossary (Continued)

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid (CMS) in order to supplement CPT codes.

HMO

Health Maintenance Organization. Provides health care services to enrolled recipients.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for all medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:
    1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
    2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
    3. Is appropriate with regard to generally accepted standards of medical practice;
    4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

POS

Place of service. A single-digit code which identifies where the service was performed.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

Index